employee benefits handbook

2005 STATE OF IOWA EMPLOYEE BENEFITS HANDBOOK

SOURCE: IOWA DEPARTMENT OF ADMINISTRATIVE SERVICES

RISK AND BENEFITS MANAGEMENT TEAM

OCTOBER 2004

where to find benefits information

You can access information about your State of Iowa benefits at our Web site:
www.das.hre.iowa.gov/benefits

Examples of the information available include:
- Links to Health and Dental Plans
- Health Plan Comparisons
- Health and Dependent Care Flexible Spending Account information
- Deferred Compensation Information
- Life and Long Term Disability insurance information
- Link to Employee Assistance Program (EAP) Website

medical plan information

Program 3 Plus and Deductible 3 Plus
(Wellmark BCBS)
1-800-622-0043
www.wellmark.com

Iowa Select and IUP Select (PPO)
(Wellmark BCBS)
1-800-622-0043
www.wellmark.com

Blue Advantage
(Wellmark BCBS)
1-800-553-7801
www.wellmark.com

Coventry Health Care of Iowa
Open Access
Primary Care
1-800-257-4692
www.chciowa.com

John Deere Health Plan
Open Access Choice
Primary Care Select
1-800-373-5050
www.johndeerehealth.com

UnitedHealthcare
1-866-473-9027
www.unitedhealthcare.com

other benefit plan information

DENTAL
Delta Dental Plan of Iowa
1-800-544-0718
www.deltadentalia.com

FLEXIBLE SPENDING ACCOUNTS
Application Software, Inc. (ASI)
1-800-659-3035
www.asiflex.com

LIFE AND LONG TERM DISABILITY
Prudential Insurance Company of America
Life Insurance
1-800-524-0542
Long Term Disability Insurance
1-800-842-1718

EMPLOYEE ASSISTANCE PROGRAM
Employee and Family Resources (EFR)
1-800-327-4692
www.efr.org/eap

DEFERRED COMPENSATION
Retirement Investors' Club
515-281-8673
www.das.hre.iowa.gov/ric

WORKERS' COMPENSATION
Sedgwick CMS
1-866-342-3920
www.sedgwickcms.com

employee benefits handbook

what's new for 2005

Health references exclude the State Police Officers' Council

This handbook contains information about your State of Iowa employee benefits.
Please keep this handbook to refer to throughout the year.

ANNUAL ENROLLMENT AND CHANGE PERIOD

The annual enrollment and change period for health plans, Flexible Spending Accounts, and Premium Conversion Plan (Pretax), will be held October 15, 2004 through November 15, 2004.

Changes will be effective January 1, 2005.

You must sign and return the appropriate enrollment forms to your Personnel Assistant no later than November 15, 2004.
(Please see your Personnel Assistant for additional enrollment materials.)

DENTAL BENEFIT CHANGES

Expanded Dental Benefits – AFSCME, AFSCME Judicial, PPME, and All Non-Contract Covered Employees Only

Employees in these categories will have expanded dental benefits effective January 1, 2005. The expanded benefits are:

	From	To
Annual Maximum Payable	$750	$1,500
Surgical Periodontal	NA	50%
Bridges and Dentures	NA	50%
Dependent Orthodontics	$750	$1,500

The State share for AFSCME, AFSCME Judicial, PPME, and all non-contract covered employees with family dental plans will be 50% effective January 1, 2005.

Dental Open Enrollment – AFSCME, AFSCME Judicial, PPME, and All Non-Contract Covered Employees Only

Employees in these categories who work 20 hours or more per week can change their dental coverage. If you previously declined coverage for yourself or your family members, if you have single coverage and wish to switch to family coverage, or if you have family coverage and want to add other eligible family members, you may enroll during this enrollment and change period.

MANAGED CARE PLAN CHANGES

Several of the Managed Care Plans have expanded their service area counties. See pages 15 and 20/21 for service area counties.

HEALTH PLANS DIFFER BY BARGAINING UNIT

Please review the Summary of Health Plan Options on page 10 to find the health plan choices that are available to you.

STATE SHARE CONTRIBUTION TOWARDS HEALTH PLAN

- For full-time employees with single coverage the State pays the full cost of the monthly premium.
- For full-time AFSCME, AFSCME Judicial, PPME, and Judicial non-contract covered employees with family coverage, the State pays 85% of the Iowa Select plan. That dollar amount is applied to all other full-time family plans.
- For full-time UE/IUP covered employees with family coverage, the State pays 72% of the Deductible 3 Plus plan. That dollar amount is applied to all other full-time family plans.
- For full-time non-contract covered employees with family coverage, the State pays 72% of the Deductible 3 Plus plan and 85% of the Iowa Select plan. The Iowa Select dollar amount is applied to all other full-time family plans.

DEFERRED COMPENSATION

- Contribution limits increase.
- Match changes.

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benefits general information

Introduction to This Handbook

The Risk and Benefits Management Team of the Iowa Department of Administrative Services developed this handbook to provide you with information about your benefit options for 2005, explain the enrollment and change process, and serve as a valuable resource for information about your benefits. It's a good idea to take some time to read this handbook before completing your enrollment forms. If you're married, you may want to share the information in this handbook with your spouse.

This handbook is not a complete description of the State of Iowa's benefit plans. Nothing in this handbook supersedes or changes any of the terms and conditions of any plan documents, insurance policies, contracts, or other legal agreements. If the wording in this handbook contradicts any plan documents, administrative rules, collective bargaining agreements, insurance policies, contracts, or other legal agreements, the wording in the official documents and agreements will govern.

If you have any questions, please call your Personnel Assistant or the appropriate vendor. You can also check our web site for more information at:
www.das.hre.iowa.gov/benefits

Quick Reference

Although it's a good idea to review this entire handbook, there are a few sections that apply to different types of enrollment.

IF YOU ARE:

ENROLLING FOR THE FIRST TIME (initial enrollment)

MAKING CHANGES DURING THE ANNUAL ENROLLMENT AND CHANGE PERIOD

MAKING CHANGES TO YOUR HEALTH CARE COVERAGE DURING THE PLAN YEAR

TERMINATING YOUR EMPLOYMENT

benefits general information

Structuring Your Benefits

The State of Iowa recognizes that employees have different needs. That's why the State offers a benefit program that allows you to choose among a number of benefit options. You can select from different benefit options to design the benefit plan that's right for you.

You are encouraged to carefully consider your personal situation as you evaluate your benefit choices. State of Iowa benefits include:

- Deferred Compensation
- Dental Insurance
- Employee Assistance Program
- Flexible Spending Accounts
- Group Life Insurance
- Health Insurance
- Long Term Disability Insurance
- Premium Conversion Program
- Tax Sheltered Annuities (Department of Education and Board of Regents only)
- Workers' Compensation

This handbook provides summary information about each of these programs.

Paying for Your Insurance Benefits

PREMIUM CONVERSION PLAN (PRETAX)

The Premium Conversion Plan (Pretax) allows you to pay your share of health, dental, and supplemental life insurance while saving money on income and FICA taxes. This means that your premiums are deducted from your salary before taxes are calculated. For example: If your monthly premium for medical, dental, and life insurance is $150 a month and your tax rate is 28%, you would be saving $42 a month, or $504 a year, in taxes. You are automatically enrolled in the plan. If you do not want to participate, you must complete a Pretax Premium Conversion Form and submit it to your Personnel Assistant. Changes can only be made within 30 days of hire, during the enrollment and change period, or at the time of a qualifying change in family or employment status.

Note that participation in this program lowers your wages for Social Security purposes and excludes you from the ability to claim your insurance premiums as medical expenses on your annual income tax forms.

UE/IUP employees who elect more than $30,000 in supplemental life insurance may be subject to imputed income taxes.
See page 26 for more information.

Eligibility for Benefits

You are eligible to participate in the plans described in this handbook if:

- You are a permanent (nontemporary) employee, and
- You work at least 20 hours a week on a regular basis (30 hours a week for life and long term disability benefits).

If you have questions about your eligibility for benefits, please see your Personnel Assistant.

If you are on leave without pay for any reason, you should check with your Personnel Assistant to see what benefits you are eligible to continue and to ensure that appropriate payments are being made.

How to Enroll

(AT THE TIME OF INITIAL EMPLOYMENT)

After you have made your decisions, you should complete the forms listed in the table below for the appropriate benefit plans. You may enroll in deferred compensation or tax sheltered annuities (if eligible) at any time.

We suggest that once you have completed all your forms, you make a photocopy of all forms for your records.

Return the forms to your Personnel Assistant within the first 30 days of employment. That's it! Insurance coverage will become effective the first day of the calendar month following the date you complete one month of continuous employment. Flexible Spending Account (FSA) enrollment will become effective no later than 30 days after the properly completed form is submitted to your Personnel Assistant.

WHICH FORMS DO I NEED TO COMPLETE TO ENROLL AT THE TIME OF INITIAL EMPLOYMENT?

BENEFIT PLAN	FORMS NEEDED	
BASIC LIFE INSURANCE	Group Life Insurance Enrollment Card	Complete the form within the first 31 days of your employment.
SUPPLEMENTAL LIFE INSURANCE	Group Life Insurance Enrollment Card (for extra $5,000 if within 31 days of employment). Beyond 31 days or above $5,000 - State of Iowa Supplemental Life Application and Evidence of Insurability. (The Evidence of Insurability must be submitted directly to the carrier.)	You can sign up for the first $5,000 on the State of Iowa Group Life Insurance Enrollment Card as long as the form is completed within the first 31 days of your employment. After that point in time, or for any additional amount, you must complete the Evidence of Insurability and Supplemental Life forms. The effective date of the additional amount will depend on approval and the timing of the approval.
DENTAL PLAN	Dental Enrollment Form	Complete the form within the first 30 days of your employment. This may be your only chance to enroll unless a special open dental enrollment is offered.
LONG TERM DISABILITY PLAN	N/A	You are automatically enrolled once you are enrolled in basic life.
MEDICAL PLAN	Medical Enrollment Form	Complete the form within the first 30 days of your employment.
PREMIUM CONVERSION PLAN (PRETAX)	Pretax Premium Conversion Program Form	You are automatically enrolled unless you request not to be within 30 days of your employment. Changes can only be made during the enrollment and change period or within 30 days of a change in family or employment status.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	State of Iowa Enrollment Agreement	You must complete the form within 30 days of your employment. Changes can only be made during the enrollment and change period or within 30 days of a change in family or employment status.
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)	State of Iowa Enrollment Agreement	You must complete the form within 30 days of your employment. Changes can only be made during the enrollment and change period or within 30 days of a change in family or employment status.

How to Make Changes

(TO HEALTH INSURANCE DURING THE ENROLLMENT AND CHANGE PERIOD)

(Health references exclude the State Police Officers Council)

ABOUT THE ANNUAL HEALTH PLAN ENROLLMENT AND CHANGE PERIOD

Each year you choose the medical plan you wish to have for the next year during the enrollment and change period. This year, the annual health plan enrollment and change period is October 15, 2004 through November 15, 2004. Changes will be effective January 1, 2005 with deductions beginning with the December 23rd paycheck. During this period, you may change your health plan as described below.

- Select any health plan offered for which you are eligible.
- If you are a new employee and this is the first enrollment and change period since your date of hire and you were not previously enrolled, you may now elect health coverage.
- If you are a new employee and this is the first annual enrollment and change period since your date of hire, you may change from single to family health coverage, or add dependents to existing family health coverage.

If you wish to stay with your current plan, no action is required.

CHANGES YOU MAY MAKE ANY TIME DURING A HEALTH PLAN YEAR

- Change from a family plan to a single plan
- Move from an Indemnity plan to a PPO plan

The effective date for the above changes is the first day of the month following the signature date on the application. It is your responsibility to notify your Personnel Assistant of any change in your family status that would affect your health and dental contract status, (i.e., divorce, death, dependent no longer eligible.

Please notify your Personnel Assistant within 30 days of these types of changes so the proper forms can be completed and if necessary, payroll deductions can be changed.

Forms Needed for Enrollment and Change Period

Enrollment Deadline is November 15, 2004.

After you have made your decisions, you should complete the forms listed in the table below for the appropriate benefit plans. If, after you have reviewed all information, you wish to stay with your current health plan and it's still offered, no form is required.

This year, there is an open dental enrollment for AFSCME, AFSCME Judicial, PPME, and all non-contract covered employees only.

We suggest that once you have completed all your forms, you make a photocopy of all forms for your records.

Return the forms to your Personnel Assistant by the November 15th deadline.

That's it! Changes will become effective January 1, 2005.

WHICH FORMS DO I NEED TO COMPLETE?

BENEFIT PLAN	FORMS NEEDED	FILE A FORM IF...
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	State of Iowa Enrollment Agreement	You wish to make your annual designation to participate in the plan.
HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)	State of Iowa Enrollment Agreement	You wish to make your annual designation to participate in the plan.
MEDICAL PLAN	Medical Enrollment Form for the Plan of Your Choice	You wish to change carriers, or, if you are a new employee and you are enrolling for the first time, or this is the first enrollment and change period since your employment and you wish to obtain coverage or add family members.
PRETAX PREMIUM CONVERSION PLAN	Pretax Premium Conversion Program Form	You wish to change your status. You were automatically enrolled unless you requested not to be within 30 days of your employment. Changes can only be made during the enrollment and change period or within 30 days of a change in family or employment status.

How to Make Health Insurance Changes at Other Times

NEW AND LATE ENROLLMENT

New employees can enroll in single or family coverage within thirty (30) calendar days following their date of employment or during the first enrollment and change period following their date of employment.

Employees, their spouses, and dependents who do not enroll during these periods or at the time of a qualified event are considered late enrollees, and are subject to an 18-month pre-existing condition(s) waiting period. The preexisting condition waiting period may be reduced by any period of other creditable health care coverage without a 63-day break in coverage.

SINGLE COVERAGE TO FAMILY COVERAGE

Under certain circumstances, employees enrolled in the group health plan or a Managed Care Organization (MCO) can change from single to family coverage or add dependents during the year without the 18-month pre-existing condition waiting period. This can be done provided that a timely application is made and that only dependents directly affected by the "event" are added to coverage. A change may be made if a new application is submitted within thirty (30) calendar days of any of the following "events:"

- Marriage;
- Death of spouse or dependent;
- Adoption of a child, addition of a stepchild, or foster child, to the family;
- Employee or spouse reaches age 65;
- Spouse or dependent, who, through no election of their own, has lost coverage;
- Employee, spouse or dependent become eligible for Medicare;
- Divorce, annulment, legal separation, or dissolution of marriage;
- Dependent no longer eligible (age 19 or over and no longer a full-time student, or dependent marries);
- Birth of a biological child – At the time of the birth of a biological child, Wellmark BCBS will add the newborn to the existing family health contract when information becomes available from any valid source that this birth occurred (e.g., hospital or professional claim submission, or an enrollment form). The effective date of the enrollment will be the date of birth. **Note: MCOs require an enrollment form to be completed by the subscriber within thirty (30) days following the birth.**

If a single contract is in effect at the time of the birth of a biological child, the enrollee must submit an application form to change to a family contract within thirty (30) days following the date of this birth. The effective date of the family contract will be the first day of the month in which the biological child was born. The employee's share of the family premium begins with the effective date.

If a single contract holder does not submit the application for family coverage within thirty (30) days following the birth of the biological child, the child will be considered a late enrollee and benefit payments will not be retroactive to the date of birth.

CHANGES YOU MAY MAKE ANY TIME DURING A HEALTH PLAN YEAR

- Change from a family plan to a single plan
- Move from an Indemnity plan to a PPO plan. The effective date for the above changes is the first day of the month following the signature date on the application.

It is your responsibility to notify your Personnel Assistant of any change in your family status that would affect your health and dental contract status, i.e., divorce, death, dependent no longer eligible. Please notify your Personnel Assistant within 30 days of these types of changes so the proper forms can be completed and if necessary, payroll deductions can be changed.

medical insurance

Summary of Medical Insurance Options

Depending on your location, you may have several medical options from which to choose. You must make a decision on which plan to choose and which of your family members to cover. The Indemnity and Preferred Provider Organization (PPO) plans are available to all employees. In addition, many areas have a Managed Care Organization (MCO) option.

Check the table on **pages 20 and 21** to see if there are any MCOs in your area.

THINGS TO CONSIDER WHEN CHOOSING A MEDICAL INSURANCE PLAN

- Make sure you choose a plan that serves your area.
- Check the Medical Plan Comparisons on pages 17-19 for a summary comparison of benefits.
- Review the monthly premium amounts on page 22.
- If you are interested in additional information about any of the carriers, please see your Personnel Assistant or call the numbers on the inside front cover.
- Make sure all the dependents you list are eligible. Eligible dependents include your spouse and your unmarried children to age 19 or unlimited age if unmarried and a full-time student.
- If you, or a member of your family, have special medical needs, call the carriers to ask about coverage for those particular needs.
- If you want to stay with your current doctor, he or she must participate in the plan you choose.
- You can set aside pretax dollars to pay for expenses not covered by your health insurance by enrolling in the Health Flexible Spending Account. See page 30 for further details.

As long as you remain enrolled in a State group, you can elect to change health plans every year without any pre-existing condition restrictions.

The plans offered to State of Iowa employees have some basic differences. It's important for you to understand those differences so that you can select the best available plan for you and your family. The following pages provide an overview of each type of plan.

medical insurance

MEDICAL INSURANCE TERMS TO KNOW

Coinsurance The percentage of the covered expenses you must pay.

Copayment (Copay) The amount that you must pay at the time a service is rendered. For example, some plans have a $10 copayment for each doctor's office visit.

Deductible The amount you pay each year toward your initial covered expenses before the Plan begins to pay benefits. Some plans do not have a deductible, or it applies to inpatient services only.

Maximum Allowable Fee The amount that equals the lesser of the covered charge for a service or supply or an amount that the insurance company establishes annually under its schedule for the same service or supply.

Out-of-Pocket Limit The most you would ever have to pay for covered medical expenses in a year. (These amounts are generally different for single and family contracts.) Once you reach the out-of-pocket limit, you will not pay for any covered expenses for the rest of the year. In some plans, pharmacy expenses and other copayments are not applied to the out-of-pocket limit.

Pre-Existing Condition Any condition for which you or an eligible dependent has received medical advice, consultation, or treatment within the 6 months prior to the date you first become eligible for medical benefits under this plan. (This may be offset by proof of other creditable coverage.)

SUMMARY OF HEALTH PLAN OPTIONS

	BARGAINING UNIT		
	AFSCME AFSCME JUDICIAL PPME JUDICIAL NON-CONTRACT	UE/IUP	NON-CONTRACT
INDEMNITY PLAN	Program 3 Plus	Deductible 3 Plus	Deductible 3 Plus
PPO Plan	Iowa Select	IUP Select	Iowa Select
MCO	Any	Any	Any

How Program 3 Plus (Indemnity) Works

AVAILABLE TO AFSCME, AFSCME JUDICIAL, PPME, AND JUDICIAL NON-CONTRACT

Wellmark BCBS Program 3 Plus, an indemnity plan, works this way:

- For office visits, you pay a $15 office visit copayment. After this copayment, you will pay 20% of covered charges. You must pay this $15 office visit copayment for all types of office visits (i.e. routine physicals, chiropractic, outpatient mental health, general office visits, etc.). This copayment will not be applied to the out-of-pocket limit.
- The Plan pays 80% of covered charges. You pay the rest (20%).
- For inpatient services, you pay for covered expenses until those expenses reach the deductible ($300 for single contracts or $400 for family contracts).
- All copayments, coinsurance, and deductibles *except $15 office visit copayment* are applied to the medical out-of-pocket limit.
  There is a separate $250/$500 out-of-pocket limit for prescription drugs. This separate out-of-pocket limit does NOT apply to the medical out-of-pocket limit.
- There are no annual or lifetime maximum benefit limits. However, certain services do have limits; for example, only one physical per year is covered.
- The pre-existing condition waiting period for new employees is 11 months. (This may be offset by proof of prior creditable coverage).
- You may go to any licensed physician or hospital. Although the majority of health care providers do accept this type of insurance, some health care providers do not participate with Wellmark BCBS. If you go to a nonparticipating provider, you could be responsible for paying additional monies out of your pocket, as that provider has not agreed to Wellmark's payment. Anything above what Wellmark allows is your responsibility.
- Your prescription drug benefits are provided through a three-tier program. This means that you pay a copayment at the time you receive your prescription until you reach your separate prescription drug out-of-pocket limit. The amount of your copayment is determined by the drug that you receive.
  Copayment amounts are:
  - $5.00 for preferred generic drugs
  - $15.00 for preferred brand name drugs, and
  - $30.00 for nonpreferred brand name **and nonpreferred generic** drugs.

If a generic equivalent is appropriate and available and you choose a brand name drug, you are responsible for the copayment plus any difference between the maximum allowable fees for the generic and brand name drug, even if the provider has specified that the brand name drug must be taken. You will be required to pay this difference even after you have reached your separate prescription out-of-pocket limit.

How Deductible 3 Plus (Indemnity) Works

AVAILABLE TO UE/IUP AND NON-CONTRACT COVERED EMPLOYEES

This indemnity plan, Wellmark BCBS Deductible 3 Plus, works this way:

- You pay an annual deductible of $300 for single contracts or $400 for family contracts each plan year. This deductible applies to ALL services before insurance coverage begins.
- The Plan pays 80% of covered charges after the deductible is met for most services. You pay the rest (20%). The following services are paid at 100% after the deductible: outpatient surgery, accidents, valid emergency, and dental accident care.
- Any portion of the deductible satisfied in the last three months of the year will be credited for the following year as well.
- All copayments, coinsurance, and deductibles are applied to the out-of-pocket limit.
- Once the deductibles, coinsurance, and copayments you have paid reach the out-of-pocket limit ($600 for single or $800 for family), any remaining covered medical expenses are paid by the Plan at 100%.
- There are no annual or lifetime maximum benefit limits. However, certain services do have limits; for example, only one physical per year is covered.
- The pre-existing condition waiting period for new employees is 11 months. (This may be offset by proof of prior creditable coverage).
- You may go to any licensed physician or hospital. Although the majority of health care providers do accept this type of insurance, some health care providers do not participate with Wellmark BCBS.

  If you elect to utilize a nonparticipating provider, you could be responsible for paying additional monies out of your pocket, as that provider has not agreed to Wellmark's payment. Anything above what Wellmark allows is your responsibility.
- Your prescription drug benefits are covered on a "cash and carry basis." This means that you pay the full cost of the prescription and are reimbursed for 80% of Wellmark's allowed amount. If you use a participating pharmacy, the pharmacist will file the claim for you, which will result in lower out-of-pocket costs, and a quicker turnaround for reimbursement. If you do not go to a participating pharmacy, you will have to submit a paper claim to Wellmark and will be reimbursed at 80% of what Wellmark would have paid to a participating pharmacy.

How Iowa Select (PPO) Works

AVAILABLE TO AFSCME, AFSCME JUDICIAL, PPME AND ALL NON-CONTRACT COVERED EMPLOYEES

Iowa Select, the Wellmark BCBS Preferred Provider Organization (PPO), works similarly to Program 3 Plus, with one major difference. Iowa Select contracts with health care service providers (hospitals, doctors, etc.) for reduced fees for each type of service. These savings are passed on to you with lower coinsurance rates (10%) if you use the network providers. You may use out-of-network providers (providers who are not part of the PPO), but then you will pay a higher coinsurance rate (20%) and are subject to the deductible.

Other Iowa Select provisions include:

- For office visits, you pay a $15 office visit copayment. After this copayment, coinsurance and deductible, if applicable, apply. You must pay this $15 office visit copayment for all types of office visits (i.e.routine physicals, chiropractic,outpatient mental health, and general office visits, etc.).
  This copayment will not be applied to the out-of-pocket limit.
- A $250 annual deductible for single coverage, which applies to both inpatient and outpatient services. The family deductible is $500.
- The deductible is waived for any services provided in the office or clinic setting of an Iowa Select physician.
- Out-of-pocket family limit of $600 ($800 for family) applies to services in- and out-of-network and includes deductibles, coinsurance, and copayments, **except the $15 office visit copayment** and prescription copays or coinsurance. There is a separate out-of-pocket limit ($250/$500) for prescription drugs. This prescription out-of-pocket limit does not apply toward the medical out-of-pocket limit.
- No annual or lifetime maximum benefit limits. However, certain services do have limits; for example, only one physical per year is covered.
- The pre-existing condition waiting period for new employees is 11 months. (This may be offset by proof of prior creditable coverage.)
- If you use network providers, you do not need to submit claim forms. The provider will do that for you.
- If you do not use network providers, you are responsible for the deductible, 20% coinsurance, plus any amount above Wellmark's allowable amount.
- Your prescription drug benefits are provided through a three-tier program. This means that you pay a copayment at the time you receive your prescription until you reach your separate prescription drug out-of-pocket limit.
  The amount of your copayment is determined by the drug that you receive.

  Copayment amounts are:
  - $5.00 for preferred generic drugs
  - $15.00 for preferred brand name drugs, and
  - $30.00 for nonpreferred brand name **and nonpreferred generic** drugs.

If a generic equivalent is appropriate and available and the member chooses a brand name drug, the member is responsible for the copayment plus any difference between the maximum allowable fees for the generic and brand name drug, even if the provider has specified that the brand name drug must be taken. You will be required to pay this difference even after you have reached your separate prescription out-of-pocket limit.

How the IUP Select (PPO) Works

ONLY AVAILABLE TO UE/IUP EMPLOYEES

IUP Select, a Wellmark BCBS Preferred Provider Organization (PPO), works similarly to Deductible 3 Plus, with one major difference. IUP Select contracts with health care service providers (hospitals, doctors, etc.) for reduced fees for each type of service. These savings are passed on to you with lower coinsurance rates (10%) if you use the network providers. You may use out-of-network providers (providers who are not part of the PPO), but then you will pay a higher coinsurance rate (20%) and are subject to the deductible.

Other IUP Select provisions include:

- A $250 annual deductible for single coverage, which applies to both inpatient and outpatient services. The family deductible is $500.
- The deductible is waived for any services provided in the office of an Iowa Select physician. Any portion of the deductible satisfied in the last three months of the year will be credited to the following year as well.
- Out-of-pocket family limit of $600 ($800 for family) applies to services in- and out-of-network and includes deductibles, coinsurance, and copayments (prescription copays or coinsurance do not apply). There is a separate out-of-pocket limit ($250/$500) for prescription drugs. This prescription out-of-pocket limit does not apply toward the medical out-of-pocket limit.
- No annual or lifetime maximum benefit limits. However, certain services do have limits; for example, only one physical per year is covered.
- The pre-existing condition waiting period for new employees is 11 months. (This may be offset by proof of prior creditable coverage.)
- If you use network providers, you do not need to submit claim forms. The provider will do that for you.
- If you do not use network providers, you are responsible for the deductible, 20% coinsurance, plus any amount above Wellmark's allowable amount.

How MCOs Work

Depending upon your location, you may have a Managed Care Organization (MCO) option. You may also have a choice in the type of MCO you can select. State of Iowa benefits currently include two types of MCO - Primary Care and Open Access. It is important that you understand the differences between types of MCOs to ensure that you choose the plan that best fits your needs.

PRIMARY CARE MCOS

Primary Care MCOs provide services that are managed by a primary care physician (PCP). You must select a PCP for each covered individual. Blue Advantage, Coventry Health Care of Iowa Primary Care, and John Deere Primary Care Select require that your PCP refer you to any specialist for special service (x-rays, tests, etc.). If you do not receive a referral from your PCP, the Plan will not pay for the service. The only exception is emergency care.

OPEN ACCESS MCOS

Open Access MCOs allow you to obtain care from any provider who participates in the MCOs network. No PCP referral is required. Coventry Health Care of Iowa Open Access, John Deere Open Access Choice, and UnitedHealthcare are all open access MCOs, and allow you to go to any provider in their network at any time.

OTHER MCO PROVISIONS INCLUDE:

- No required deductibles. However, there are coinsurance and copayments that vary by service provided.
- Prescription copayments do not apply to the out-of-pocket maximum.
- There are no annual or lifetime maximum benefit limits. However, certain services do have limits; for example, only one physical per year may be covered.
- Emphasis on preventive services, with 100% coverage for an annual physical, well baby care, screening mammograms, and disease management programs.
- No need to fill out any claim forms.
- No pre-existing condition waiting period for new employees.
- If you receive care from an out-of-network provider, unless it is an emergency, you are responsible for full payment.
- Not all of the MCOs are available in all areas. Please note listings below.

NEW COUNTIES SERVED: Cerro Gordo, Hancock, Howard, Humboldt, Kossuth, Mitchell, Palo Alto, Winnebago, Worth, and Wright.

COUNTIES NOT SERVED BY A MANAGED CARE PLAN: Allamakee, Buena Vista, Cherokee, Clay, Decatur, Dickinson, Emmet, Ida, Lyon, O'Brien, Osceola, Page, Pocahontas, Ringgold, Sioux, Taylor, Union, Webster, and Winneshiek.

Medical Care Management Features

All of the medical plans have built in features that are meant to coordinate and manage your medical care. Some MCOs, for example, have a PCP who is assigned the task of managing your total medical care. All the plans have some features that help manage your medical care so that you receive the care you need in a cost-effective manner. Some of these features include:

PREAPPROVAL OF HOSPITAL ADMISSIONS

Some plans require preapproval of your hospital admission before you go to the hospital. Of course, in an emergency, get help first and then call the plan to let them know about your hospitalization.

SECOND SURGICAL OPINIONS

In most cases, getting a second surgical opinion is voluntary. In some cases it is required. The charges for a second surgical opinion are paid according to the normal plan benefits.

LARGE CASE MANAGEMENT

In cases that require a multitude of services for a longer period of time, alternative care may be recommended.

MENTAL HEALTH AND CHEMICAL DEPENDENCY (MHCD) TREATMENT

In all plans, MHCD treatment is covered. Copayments, coinsurance, inpatient days and outpatient visits have calendar year maximums. Several plans require pre-certification for outpatient treatment. If you do not precertify, benefits will be reduced.

Program 3 Plus, Deductible 3 Plus, Iowa Select, and IUP Select require the use of the mental health network for inpatient and outpatient services. In addition, you must precertify inpatient and outpatient care by calling a Wellmark BCBS Nurse Reviewer at 1-800-558-4409 (24 hours day). If you do not precertify, or use an out-of-network provider, benefits will be reduced by 50%, or denied, if services are not medically necessary.

AFSCME, AFSCME Judicial, PPME, and Judicial Non-Contract Medical Plan Comparison – What You Pay

The three types of medical plans vary in access to providers, first expenses (deductibles), out-of-pocket limits, and the portion you have to pay. For a comparison of the plans see the chart below.

SERVICE/PLAN	PROGRAM 3 PLUS	IOWA SELECT PPO	MCO
Access to Providers	Full Access	Lower level of benefits if not in the network	Varies; see below[1]
Coinsurance Percentage	20%	10%/20% [2]	Varies by service
Deductibles Single Family	Inpatient Only $300 $400	Waived only for in-network office/clinic setting $250 $500	None
Dependent child age limit[3]	19/unlimited	19/unlimited	19/unlimited
Emergency Room Care	100%, no deductible	$50.00 copayment; waived if admitted. Copayment and co-insurance apply. Copayment applies after out-of-pocket limit is met.	$50.00 copayment; waived if admitted.
Hospital Services	20%, after deductible with prior authorization	10%/20%, after deductible. Select provider must obtain prior authorization	100% paid, if authorized
Lifetime Maximum	None	None	None
Mail Order Prescription Drugs	Covered as below for maintenance drugs for up to a 90 day supply for two copayments instead of three.	Covered as below for maintenance drugs for up to a 90 day supply for two copayments instead of three.	Up to a 90-day supply for: $10 copay (generic) $30 copay (preferred brand name) $60 copay (non-preferred brand name and non-preferred generic)
Out-of-Pocket Limits Single Family	$600 $800 All copayments, deductible, and coinsurances, except $15 office visit copayment, apply. Separate $250/$500 out-of-pocket limit for prescription drugs, does not apply to medical out-of-pocket limit.	$600 $800 All deductible, coinsurances, and copayments, except $15 office visit copayment, apply. ER care copayment continues to apply after out-of-pocket limit is met. Separate $250/$500 out-of-pocket limit for prescription drugs; does not apply to medical out-of-pocket limit.	$750 $1,500 All copayments, except prescription drug copayments, apply
Physicians Office Visit	$15 copayment. 20% coinsurance, no deductible. Copayment does not apply to out-of-pocket limit.	$15 copayment. 10%/20%, coinsurance after deductible; deductible waived for in-network office/clinic setting. Copayment does not apply to out-of-pocket limit.	$10 copay
Prescription Contraceptive Drugs & Contraceptive Devices	Covered	Covered	Covered
Prescription Drugs	$5 copay (preferred generic)[4] $15 copay (preferred brand name) $30 (non-preferred brand name and non-preferred brand name and non-preferred generic)	$5 copay (preferred generic)4 $15 copay (preferred brand name) $30 (non-preferred brand name and non-preferred generic)	$5 copay (preferred generic) $15 copay (preferred brand name) Greater of $30 or 25% (non-preferred brand name and non-preferred generic)
Routine Physicals (limit to one per year)	20%	10%/20%	$10 copay
Well Child Care[5]	20%	10%/20%, no deductible	$10 copay

1. Coventry Health Care of Iowa Open Access, John Deere Open Access Choice, and UnitedHealthcare provide access to any network provider. Blue Advantage, Coventry Primary Care and John Deere Primary Care Select require a primary care physician referral. 2. Network/non-network providers. 3. Age to which unmarried dependents are covered whether full-time students or not/age to which dependents are covered if unmarried and fulltime students. 4. If a generic equivalent is appropriate and available and the member chooses a brand name drug, the member is responsible for the copayment plus any difference between the maximum allowable fees for the generic and brand name drug, even if the provider has specified that the brand name must be taken. 5. Well child care is through age 7.

UE/IUP Medical Plan Comparison – What You Pay

The three types of medical plans vary in access to providers, first expenses (deductibles), out-of-pocket limits, and the portion you have to pay. For a comparison of the plans see the chart below.

SERVICE/PLAN	DEDUCTIBLE 3 PLUS	IUP SELECT PPO	MCO
Access to Providers	Full Access	Lower level of benefits if not in the network	Varies; see below[1]
Coinsurance Percentage	20%	10%/20%[2]	Varies by service
Deductibles Single Family	Applies to ALL services $300 $400	Waived only for in-network office/clinic setting $250 $500	None
Dependent child age limit[3]	19/unlimited	19/unlimited	19/unlimited
Emergency Room Care	0%, after deductible	$50.00 copayment; waived if admitted. Deductible, copayment and co-insurance apply. Copayment applies after out-of-pocket limit is met.	$50.00 copayment; waived if admitted.
Hospital Services	20%, after deductible with prior authorization	10%/20%, after deductible with prior authorization	100% paid, if authorized
Lifetime Maximum	None	None	None
Mail Order Prescription Drugs	Not Available	Not Available	Up to a 90-day supply for: $10 copay (generic) $30 copay (preferred brand name) $60 copay (non-preferred brand name and non-preferred generic)
Out-of-Pocket Limits Single Family	$600 $800 All copayments, deductible, and coinsurances apply to out-of-pocket limit	$600 $800 All deductible, coinsurances, and copayments apply. ER care copayment continues to apply after out-of-pocket limit is met. Separate $250/$500 out-of-pocket limit for prescription drugs; does not apply to medical out-of-pocket limit.	$750 $1,500 All copayments, except prescription drug copayments, apply
Physician Office Visits	20%, no deductible	10%/20%, after deductible; deductible waived for in-network office/clinic setting	$10 copay
Prescription Contraceptive Drugs & Contraceptive Devices	Covered	Covered	Covered
Prescription Drugs	20%, after deductible	20%, no deductible $250/$500 out-of-pocket limit	$5 copay (preferred generic) $15 copay (preferred brand name) Greater of $30 or 25% (non-preferred brand name and non-preferred generic)
Routine Physicals (limit to one per year)	20%, after deductible	10%/20%	$10 copay
Well Child Care[4]	20%, after deductible	10%/20%, no deductible	$10 copay

1. Coventry Health Care of Iowa Open Access, John Deere Open Access Choice, and UnitedHealthcare provide access to any network provider. Blue Advantage, Coventry Primary Care and John Deere Primary Care Select require a primary care physician referral. 2. Network/non-network providers. 3. Age to which unmarried dependents are covered whether full-time students or not/age to which dependents are covered if unmarried and fulltime students. 4. Well child care is through age 7.

Non-Contract Medical Plan Comparison – What You Pay

The three types of medical plans vary in access to providers, first expenses (deductibles), out-of-pocket limits, and the portion you have to pay. For a comparison of the plans see the chart below.

SERVICE/PLAN	DEDUCTIBLE 3 PLUS	IOWA SELECT PPO	MCO
Access to Providers	Full Access	Lower level of benefits if not in the network	Varies; see below[1]
Coinsurance Percentage	20%	10%/20%[2]	Varies by service
Deductibles Single Family	Applies to ALL services $300 $400	Waived only for in-network office/clinic setting $250 $500	None
Dependent child age limit[3]	19/unlimited	19/unlimited	19/unlimited
Emergency Room Care	0%, after deductible	$50.00 copayment; waived if admitted. Copayment and co-insurance apply. Copayment applies after out-of-pocket limit is met.	$50.00 copayment; waived if admitted.
Hospital Services	20%, after deductible with prior authorization	10%/20%, after deductible. Select provider must obtain prior authorization	100% paid, if authorized
Lifetime Maximum	None	None	None
Mail Order Prescription Drugs	Not Available	Covered as below for maintenance drugs for up to a 90 day supply for two copayments instead of three.	Up to a 90-day supply for: $10 copay (generic) $30 copay (preferred brand name) $60 copay (non-preferred brand name and non-preferred generic)
Out-of-Pocket Limits Single Family	$600 $800 All copayments, deductible, and coinsurances apply to out-of-pocket limit	$600 $800 All deductible, coinsurances, and copayments, except $15 office visit copayment, apply. ER care copayment continues to apply after out-of-pocket limit is met. Separate $250/$500 out-of-pocket limit for prescription drugs; does not apply to medical out-of-pocket limit.	$750 $1,500 All copayments, except prescription drug copayments, apply
Physician Office Visits	20%, no deductible	$15 copayment. 10% /20$% coinsurance after deductible; deductible waived for in-network office/clinic setting. Copayment does not apply to out-of-pocket limit.	$10 copay
Prescription Contraceptive Drugs & Contraceptive Devices	Covered	Covered	Covered
Prescription Drugs	20%, after deductible	$5 copay (preferred generic)[4] $15 copay (preferred brand name) $30 (non-preferred brand name and non-preferred generic)	$5 copay (preferred generic) $15 copay (preferred brand name) Greater of $30 or 25% (non-preferred brand name and non-preferred generic)
Routine Physicals (limit to one per year)	20%, after deductible	10%/20%	$10 copay
Well Child Care[5]	20%, after deductible	10%/20%, no deductible	$10 copay

1. Coventry Health Care of Iowa Open Access, John Deere Open Access Choice, and UnitedHealthcare provide access to any network provider. Blue Advantage, Coventry Primary Care and John Deere Primary Care Select require a primary care physician referral. 2. Network/non-network providers. 3. Age to which unmarried dependents are covered whether full-time students or not/age to which dependents are covered if unmarried and fulltime students. 4. If a generic equivalent is appropriate and available and the member chooses a brand name drug, the member is responsible for the copayment plus any difference between the maximum allowable fees for the generic and brand name drug, even if the provider has specified that the brand name must be taken. 5. Well child care is through age 7.

2005 Managed Care Service Area

Each health insurance carrier has determined that the following counties have adequate participating providers to offer services as noted. Please check the provider directories for any plans that interest you to ensure that there are participating doctors, specialists, labs, hospitals, clinics, etc. in your area. **VERY IMPORTANT: Services will not be paid by the carrier if you do not go to participating providers for all your health care needs.**

County	Blue Adv.	Coventry Open	Coventry Primary	John Deere Open Access Choice	John Deere Primary Care Select	UnitedHealthcare
Adair		X	X			X
Adams						X
Allamakee						
Appanoose	X			X	X	X
Audubon						X
Benton	X	X	X	X	X	
Black Hawk	X	X	X	X	X	X
Boone	X	X	X	X	X	X
Bremer	X	X	X	X	X	X
Buchanan	X			X	X	
Buena Vista						
Butler	X	X	X	X	X	X
Calhoun				X	X	
Carroll		X		X	X	
Cass						X
Cedar	X			X	X	
Cerro Gordo				X	X	X
Cherokee						
Chickasaw				X	X	X
Clarke	X	X	X	X	X	X
Clay						
Clayton	X			X	X	X
Clinton	X			X		X
Crawford						X
Dallas	X	X	X	X	X	X
Davis	X			X	X	X
Decatur						
Delaware	X			X	X	X
Des Moines				X		
Dickinson						
Dubuque				X	X	X
Emmet						
Fayette				X	X	
Floyd				X	X	
Franklin				X	X	
Fremont						X
Greene		X		X	X	
Grundy	X	X	X	X	X	X
Guthrie	X	X	X	X	X	X
Hamilton		X		X	X	
Hancock				X	X	
Hardin				X	X	X
Harrison						X
Henry				X	X	
Howard				X	X	
Humboldt				X	X	
Ida						
Iowa	X	X	X	X	X	
Jackson	X			X	X	X

2005 Managed Care Service Area

Each health insurance carrier has determined that the following counties have adequate participating providers to offer services as noted. Please check the provider directories for any plans that interest you to ensure that there are participating doctors, specialists, labs, hospitals, clinics, etc. in your area. **VERY IMPORTANT: Services will not be paid by the carrier if you do not go to participating providers for all your health care needs.**

County	Blue Adv.	Coventry Open	Coventry Primary	John Deere Open Access Choice	John Deere Primary Care Select	UnitedHealthcare
Jasper	X	X	X	X	X	X
Jefferson	X			X	X	
Johnson	X			X	X	
Jones	X			X	X	
Keokuk	X			X	X	
Kossuth				X	X	
Lee				X		
Linn	X	X	X	X	X	
Louisa	X			X		
Lucas	X	X	X	X	X	X
Lyon						
Madison	X	X	X	X	X	X
Mahaska	X			X	X	
Marion	X	X	X	X	X	X
Marshall	X			X	X	
Mills	X					X
Mitchell				X	X	
Monona						X
Monroe	X			X	X	
Montgomery						X
Muscatine	X			X	X	X
O'Brien						
Osceola						
Page						
Palo Alto				X	X	
Plymouth		X	X			
Pocahontas						
Polk	X	X	X	X	X	X
Pottawattamie	X					X
Poweshiek		X	X	X		
Ringgold						
Sac				X	X	
Scott	X			X	X	X
Shelby	X					X
Sioux						
Story	X	X	X	X	X	X
Tama	X			X	X	
Taylor						
Union						
Van Buren	X			X		
Wapello	X			X	X	
Warren	X	X	X	X	X	X
Washington	X			X	X	
Wayne	X	X	X	X	X	X
Webster						
Winnebago				X	X	
Winneshiek						
Woodbury		X	X			X
Worth				X	X	
Wright				X	X	

Monthly Health Insurance Premiums

The State of Iowa pays the full cost of your coverage if you are a full-time employee with single coverage. If you choose family coverage, the State pays the majority of the premium and you pay the remainder as listed below. These rates are for active full-time employees only. If you are part-time, disabled, retired, or covered by COBRA, call your Personnel Assistant for your rates.

Family Monthly Premium — Your Portion

PLAN	AFSCME AFSCME JUDICIAL PPME JUDICIAL NON-CONTRACT	UE/IUP	NON-CONTRACT
Program 3 Plus (Wellmark BCBS)	$222.56	N/A	N/A
Iowa Select (PPO) (Wellmark BCBS)	$155.48	N/A	$155.48
Deductible 3 Plus (Wellmark BCBS)	N/A	$308.06	$308.06
IUP Select (Wellmark BCBS)	N/A	$305.98	N/A
Blue Advantage (Wellmark BCBS)	$0.00	$0.00	$0.00
Coventry Health Care of Iowa Open Access	$55.36	$144.24	$55.36
Coventry Health Care of Iowa Primary Care	$23.32	$112.20	$23.32
John Deere Open Access Choice	$212.36	$301.24	$212.36
John Deere Primary Care Select	$0.00	$60.98	$0.00
UnitedHealthcare	$34.42	$123.30	$34.42

Dental Insurance

(Dental references exclude the State Police Officers Council.)

For more information, call Delta Dental Plan of Iowa at 1-800-544-0718

OPEN DENTAL ENROLLMENT OPPORTUNITY – AFSCME, AFSCME JUDICIAL, PPME, AND ALL NON-CONTRACT ONLY

If the proper dental enrollment form is signed and submitted between October 15, 2004 and November 15, 2004, employees not previously enrolled may enroll in single or family coverage, and employees currently enrolled may add their spouse or dependents. Coverage will be effective January 1, 2005.

AFSCME, AFSCME JUDICIAL, PPME, AND ALL NON-CONTRACT DENTAL PROVISIONS

There are expanded dental benefits for employees in the above bargaining units and status effective January 1, 2005. The expanded dental plan pays up to $1,500 of covered expenses per person per year, as follows:

- 100% for routine check-ups and cleanings every six months;
- 80% for routine restorative services, such as fillings;
- 50% for non-surgical and surgical periodontal treatments, root canals, and crowns (must have prior approval);
- 50% for bridges and dentures (prosthetics); and
- 50% for dependent orthodontia (unmarried dependent children under 19 only); no deductible; up to $1,500 per eligible dependent in a lifetime.

MONTLY PREMIUM FOR AFSCME, AFSCME JUDICIAL, PPME, AND ALL NON-CONTRACT DENTAL INSURANCE

The State pays the cost of single coverage, which is $24.55 a month. For family coverage, you pay $32.88 per month. These rates are for active, full-time employees only. If you are part-time, disabled, retired, or covered by COBRA, call your Personnel Assistant for your rates.

UE/IUP DENTAL INSURANCE PROVISIONS

The plan pays up to $750 of covered expenses per person per year, as follows:

- 100% for routine check-ups and cleanings every six months;
- 80% for routine restorative services, suc as fillings;
- 50% for nonsurgical periodontal treatments, root canals, and crowns (must have prior approval); and
- 50% for dependent orthodontia (unmarried dependent children under 19 only); no deductible; up to $750 per eligible dependent in a lifetime.

MONTHLY PREMIUM FOR UE/IUP DENTAL INSURANCE

The State pays the cost of single coverage, which is $20.20 a month. For family coverage, you pay the additional $33.88 per month. These rates are for active, full-time employees only. If you are part-time, disabled, retired, or covered by COBRA, call your Personnel Assistant for your rates.

dental insurance

THINGS TO CONSIDER

- You can only enroll during the first 30 days of your employment.
- Dependents can only be added during your initial enrollment or as a result of a qualifying event such as marriage, birth, or adoption.
- Only those dependents directly affected by the event may be added. See the list of events below.
- Make sure the dependents you cover are eligible. Eligible dependents inlcude your spouse and unmarried, dependent children under age 19 or full-time students.
- You can set aside pretax dollars to pay for expenses not covered by your dental insurance by enrolling in the Health Flexible Spending Account. See page 30 for further details.
- You can change from family to single coverage at any time.

QUALIFYING EVENTS FOR MAKING CHANGES TO DENTAL INSURANCE

You must have one of the following qualifying events in order to change your dental plan enrollment. If you are not currently enrolled in the dental plan, these events will not allow you to join the plan.

- Marriage;
- Death of a spouse or dependent;
- Adoption of a child, or addition or a step or foster child;
- Employee or spouse reaches age 65;
- Employee, spouse, or dependent becomes eligible for Medicare;
- Divorce, annulment, legal separation, or dissolution of a marriage;
- Dependent no longer eligible (age 19 or over and no longer a full-time student, or dependent marries);
- Spouse loses coverage through another employer due to involuntary loss of employment (lay-off, discharge, business closing). (Proof of loss shall be the "Involuntary Loss of Coverage Statement" signed and dated by the previous employer.)
- Birth of a biological child: If moving from single to family, the effective date of the family contract will be the first day of the month in which the child is born. Family premiums will begin with this effective date. If a single contract holder does not submit the application for family coverage within 30 days of the birth, there is no further opportunity to add the newborn.

A dental enrollment/change form is always required when adding a newborn.

life insurance

Summary of Life Insurance

The State offers two forms of group term life insurance - Basic and Supplemental; Prudential Insurance Company of America administers both plans. The State of Iowa's Basic and Supplemental group life insurance is term life, meaning there is no cash value associated with the policy. Basic and Supplemental life insurance coverage amounts begin to decrease starting at age 65. Additional information about basic and supplemental life insurance is provided in the following sections.

LIFE INSURANCE PREMIUMS

The State pays the entire premium for your Basic life insurance coverage. You can purchase Supplemental (additional) life insurance through payroll deduction. See your Personnel Assistant for premium information.

LIFE INSURANCE BENEFICIARY

Please be sure your beneficiary information is current. To change your beneficiary designation, see your Personnel Assistant for the current beneficiary change form.

Basic Life Insurance

If you work 30 or more hours per week and are under age 65, you are eligible for basic group term life coverage in the amount of $10,000 ($20,000 for UE/IUP and State Police Officers' Council employees). The State pays the entire premium for basic coverage. You are enrolled for basic life insurance coverage when DAS-HRE receives your properly completed basic life enrollment card within 31 days from your date of hire.

If you do not complete and submit your life insurance card, you will not have life insurance through the State's group plan. In addition, because you are not enrolled for Long Term Disability (LTD) insurance until you complete and submit your life card, you will not be covered by the State's group LTD plan.

Supplemental Life Insurance

You can obtain additional life insurance coverage by participating in the Supplemental Life Insurance plan. This plan allows you to purchase additional life insurance in $5,000 increments to a maximum of $40,000 ($30,000 for State Police Officers' Council employees).

You can obtain the first $5,000 of Supplemental Life insurance without providing "evidence of insurability" if you enroll within the first 31 days of employment. If you do not apply for the first $5,000 of Supplemental Life insurance within 31 days of employment, you will have to provide "evidence of insurability" to Prudential.

LIVING BENEFIT OPTION

If you are diagnosed with a terminal illness and have a life expectancy of 6 months or less, you may be able to have up to 75% of your life insurance benefits paid to you while you are still living. Proceeds can be paid in a lump sum or in monthly installments.

ACCIDENTAL DEATH AND DISMEMBERMENT

An amount equivalent to your Basic and Supplemental life coverage is provided for accidental death and a percentage of your basic and supplemental life coverage is provided for accidental dismemberment. Certain exclusions apply; consult your booklet certificate.

SEAT BELT BENEFIT

If an accidental death occurs while an employee is wearing a seat belt in the prescribed manner, the plan pays an additional benefit of 10% of the employee's coverage amount, up to $6,000.

AIR BAG BENEFIT

If an accidental death occurs while an employee is riding in an automobile seat equipped with an air bag system and wearing a seat belt, the plan pays an additional benefit of 10% of the employee's coverage amount, up to $6,000.

How to Make Changes

INCREASING COVERAGE

You can add coverage at any time. However, all amounts greater than the original $5,000 (if obtained within 31 days of employment) require that "evidence of insurability" be sent to Prudential.

DECREASING COVERAGE

You can decrease your life insurance coverage at any time. Contact your Personnel Assistant for an application for supplemental life insurance.

BENEFICIARY CHANGES

You can change your life insurance beneficiary at any time. Your Personnel Assistant can provide you with the form you need to make a change. Changes to beneficiary information are not effective until received by your Personnel Assistant.

THINGS TO CONSIDER (ABOUT HOW MUCH INSURANCE TO PURCHASE)

- If you're trying to determine how much insurance to purchase, remember that this benefit is meant to help those who would suffer financially if you weren't there to help pay the bills.

Here are a few factors to consider:

- Mortgage, debts, food, clothes, and utility bills (the portion of these that are paid from your salary).
- Housekeeping bills (if you contribute to the running of the household by performing household tasks or running errands).
- Extra childcare expenses (to give your spouse some time off).
- Savings for children's education.
- The cost of a funeral.

HOW TO ENROLL IN SUPPLEMENTAL LIFE INSURANCE

Once you decide on the amount of supplemental life insurance that you need, see your Personnel Assistant for forms.

IMPUTED INCOME FOR UE/IUP EMPLOYEES ONLY

If your total group life insurance coverage (basic and supplemental) is over $50,000 and you pay for supplemental life insurance on a pretax basis, you may have imputed income reported to the IRS. The value (determined by a cost table from the IRS) of the life insurance over $50,000 may be reported as imputed income and may be subject to taxes. The monthly value increases with age from $.05 per $1,000 of insurance for those under age 25 to $2.06 per $1,000 for those ages 70 and over.

For more information about your coverage, please see your State of Iowa Group Life Insurance booklet, ask your Personnel Assistant, or call Prudential at 1-800-842-1718.

long term disability insurance

Long Term Disability Insurance

(Employees working 30 or more hours per week)

The LTD Plan provides monthly benefits if you have a disability that prevents you from performing those tasks required by your regular occupation.

We automatically enroll you in the Long Term Disability (LTD) Plan when we receive your Basic Life Card. Prudential Insurance Company of America administers the State's LTD plan. 100% of your coverage is paid for by the State.

GENERAL ASSEMBLY EMPLOYEES

If you are a part-time employee of the General Assembly you must pay for LTD insurance coverage. See your Personnel Assistant for more information.

LONG TERM DISABILITY BENEFITS

If you are approved for LTD benefits, they will begin on the first day following the "elimination period." The elimination period begins on your last day at work and continues through the later of 90 working days or the exhaustion of sick leave. Benefits will be paid if a disability prevents you from performing your regular occupation. An evaluation to determine continuation of benefits will occur twelve months from your last day at work. To continue to receive benefits after the initial twelve months, you must have a disability that prevents you from performing any gainful occupation or work for which you are or could become qualified for by training, education, or experience. Mental health and substance abuse disabilities are limited to 12 months. If you are approved for LTD, you may not receive donated leave.

Pre-existing conditions are excluded if the disability begins within 12 months of the date the coverage begins. A pre-existing condition is one for which you received medical treatment, consultation, care or services including diagnostic measure, took prescribed drugs or medicines, or followed treatment recommendations, or had symptoms for which an ordinarily prudent person would have consulted a health care provider, in the 12 months just prior to your effective date of coverage.

LTD benefits are based upon your years of continuous full-time employment with the State of Iowa. If you have been employed less than one year, the LTD benefit is 20% of your covered monthly salary (20% of up to $40,000 annual salary). If you have been employed for one year, but less than two years, the LTD benefit is 40% of your covered monthly salary (40% of up to $40,000 annual salary). If you have been employed for two or more years, the LTD benefit is 60% of your covered monthly salary (60% of up to $40,000 annual salary).

long term disability insurance

REHABILITATION REQUIREMENT

If Prudential has come up with a rehabilitation plan for you which was approved by your doctor and you choose not to follow it, then your benefits will end.

RETURN TO WORK INCENTIVE

If you participate in a rehabilitation program offered by Prudential, you may be able to receive additional benefits such as:

- Monthly rehabilitation payments,
- Monthly day care payments, and
- Spouse and elder care payments

See the LTD booklet certificate for more information about rehabilitation and return to work benefits.

SURVIVOR BENEFIT

When Prudential receives proof that you have died, they will pay your eligible survivor (spouse, if living, otherwise, your children under age 25) a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate. Prudential will first apply the survivor benefit to any overpayment that may exist on your claim.

WHEN BENEFITS END

If you are approved to receive LTD benefits, they will continue until the earlier of:

- you reach normal retirement age (unless age 61 or over on date of disability)
- your disability ends
- you fail to participate in a rehabilitation program.

Other terms and conditions may apply; consult the LTD booklet certificate.

CONTINUATION OF LIFE INSURANCE

If you are approved for long term disability before you reach the age of 60, your basic and supplemental life insurance continues, and your insurance premiums are waived. If you are over the age of 60 when you become disabled, you have up to 31 days from the date you cease active work to convert your life insurance to an individual policy. Supplemental Life Insurance premium payment must continue during the qualifying period for LTD.

If you are receiving long term disability payments and return to any employment, whether it is with the State or not, you must contact Prudential immediately to determine what impact your employment may have on your long term disability benefits.

THINGS TO CONSIDER ABOUT THE LTD PLAN

The maximum LTD benefit is $2,000 per month (60% of your salary up to $3,333.33 per month or $40,000 a year). Long term disability payments are reduced by any other income benefits such as benefits received from Workers' Compensation or Social Security Disability Income. If you need to insure the remainder of your salary, you should investigate buying additional LTD coverage through your insurance agent or insurance company.

Please note that LTD benefits payable through other group plans will reduce your State of Iowa group LTD benefit payment.

The LTD plan does not cover any disabilities caused by:

- intentionally self-inflicted injuries;
- active participation in a riot;
- commission of a crime for which you have been convicted under state or federal law; or
- war, whether declared or undeclared.

The plan also will not pay benefits during any period in which you are incarcerated as a result of a conviction.

For more information about your coverage, please see your State of Iowa Group Long Term Disability booklet, ask your Personnel Assistant, or call Prudential at 1-800-842-1718.

LTD TERMS TO KNOW

Disabled You are disabled when Prudential determines that:

- you are unable to perform the material and substantial duties of your regular occupation due to your sickness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to that sickness or injury.

After 12 months of benefits, you are disabled when Prudential determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

Elimination Period The latter of the first 90 working days of any single period of Total Disability, or the date that the employee has exhausted all sick leave.

Gainful Occupation A gainful occupation means an occupation, including self-employment that does, or can be expected to, provide you with an income equal to at least 60% (or 20% or 40% if you have been employed less than two years) of your indexed monthly earnings within 12 months of your return to work.

Regular Occupation Your regular occupation is the occupation you are routinely performing when your disability begins. Prudential will look at your occupation as it is normally performed instead of how the work tasks are performed for a specific employer or at a specific location.

flexible spending accounts

WHAT ARE THEY?

Many employees pay for health and dependent care expenses on a regular basis. Did you know that the State of Iowa provides a way for you to save money on these expenses? Flexible Spending Accounts (FSAs) let you pay for certain health (through the Health FSA) and dependent care expenses (through the Dependent Care FSA) with tax-free dollars. This benefit saves you money by reducing your taxable income and increasing your spendable income. You contribute to one or both of the State's FSA accounts with pretax dollars and then are reimbursed for qualifying expenses for you and your family. Pretax dollars are not subject to state, federal, or FICA taxes.

The amount you designate for the year is divided into 24 equal amounts and held in your flexible spending account(s). When you submit receipts for eligible expenses, you draw your pretax money out of your FSA. You can choose to have payments mailed to you or deposited directly into your checking or savings account.

More information about this program is available on our website at www.das.hre.iowa.gov/benefits_flex_spending or from Application Software, Inc. (ASI), the State's third party administrator. ASI can be reached at 800-659-3035 or www.asiflex.com/iowa.

Health Flexible Spending Accounts

HOW DOES IT WORK?

When you incur an eligible medical expense, you complete a claim form, attach appropriate documentation and mail to ASI. You will receive payment from ASI by check or direct deposit, depending upon your election when you enroll. A medical expense is incurred when the services are provided that create the expense, not when you are billed for or pay for the service. You must receive the medical services before you file a claim for those services. You pay the medical bill directly, either at the time of service or later.

HOW MUCH CAN I CONTRIBUTE?

The maximum you are allowed to contribute to this FSA is $2,500 a year per participant. If your spouse is eligible to participate in a health flexible spending program, he or she may also contribute to his or her employer's plan. You cannot claim the same expense on both participants' plans.

WHAT IS AN ELIGIBLE EXPENSE?

Some examples of items that may be eligible for reimbursement under the Health FSA if they are not covered by insurance are:

- Medical copayments and deductibles
- Prescription drug copayments
- Dental charges in excess of insurance coverage
- Eye glasses and contact lenses
- Hearing aids
- Over-the-counter medicine used to treat a medical condition
- Medically necessary weight loss programs as prescribed by a physician (health club dues and special foods do not qualify).

A complete list of eligible expenses is available in Internal Revenue Service Publication 502. However, insurance premiums and long term care expenses are not eligible even though they are mentioned in IRS Publication 502.

Expenses must be incurred during your period of coverage and during the plan year. The following are not eligible expenses:

- products advertised, marketed, or offered as long-term care insurance;
- medical savings accounts under section 106(b).

WHAT HAPPENS WHEN I LEAVE STATE EMPLOYMENT?

If you leave State employment and are enrolled in the Health FSA, you may be able to continue participating in the Health FSA if you meet certain requirements. Continuation of coverage will be provided if, on the date of the qualifying event, your remaining benefits for the current plan year are greater than your remaining program contribution payments.

Qualifying events include termination of employment, death, divorce, or dependent loss of eligibility. You must notify the plan administrator if any of these events, other than termination of employment, apply to you.

Your right to elect to continue coverage ends 60 days from the date on the continuation notice provided by the plan administrator. If continuation is elected, the remaining program contributions will be charged to you, your spouse, or dependent, as the case may be, for any period of continuation coverage at 102% of the cost of providing coverage for the period to similarly situated participants, spouses, or dependents.

Continuation will only be extended to the end of the current plan year but may terminate sooner if the premiums described above are not paid within 30 days of the due date.

If you meet the eligibility criteria for continued participation in the Health FSA you will be notified by the Department of Administrative Services. If you elect to continue participation you must pay your contributions plus a 2% administration fee.

Dependent Care Flexible Spending Account

HOW DOES IT WORK?

When you incur an eligible dependent care expense, complete a claim form, attach appropriate documentation, and mail it to ASI. You will receive payment from ASI by check or direct deposit, depending upon the payment election you make when you enroll. A dependent care expense is incurred when the services are provided that create the expense, not when you are billed for or pay for the service. You will only receive reimbursement for the amount that you have contributed through payroll deduction.

HOW MUCH CAN I CONTRIBUTE?

Dependent Care FSA maximum contribution amounts depend on whether you are single or married and on your tax filing status. You cannot contribute more than your or your spouse's earned income. The maximum contribution amounts are:

- $5,000 if you are single, or married and file a joint return.
- $2,500 if you are married and file separate returns.
- $5,000 combined maximum if your spouse also contributes to a dependent care account.
- $3,000* if your spouse is a full-time student and you have one dependent.
- $5,000* if your spouse is a full-time student and you have more than one dependent.

*Beginning January 1, 2003

WHAT IS AN ELIGIBLE EXPENSE?

Each year, you can set aside pretax dollars to cover expenses for dependents if:

- They are under age 13; or
- They are mentally or physically incapable of selfcare and reside in your home at least eight hours a day, regardless of age; and
- You claim them as dependents for federal income tax purposes.

If you are married, to be eligible your spouse must either:

- Be a full-time student;
- Work; or
- Be incapable of self-care.

In addition:

- Expenses must be for care that enables both spouses to work; and
- If your spouse works, his or her income must be greater than the reimbursement of dependent care expenses.

You are not eligible for dependent care participation during periods in which you are not at work. If you are on leave, including workers' compensation or maternity leave, you are not eligible to participate and cannot receive reimbursement for expenses incurred during your leave period.

Eligible expenses include:
- In-home day care
- Day care at someone's house
- Nursery school
- Adult day care (dependent must live in home for at least eight hours a day)
- Boarding school (the portion of the cost used for care of the dependent under age 13)
- Dependent care centers (that comply with state and local laws and licensing requirements)
- Household services (if the dependent is being cared for in the home and the household services are necessary for the dependent's care)
- Preschool
- Summer day camp (if the child does not stay overnight), but not instructional camps.

The following are not eligible expenses:
- qualified scholarships under section 117;
- educational assistance programs under section 127;
- fringe benefits under section 132; and
- transportation expenses.

WHAT HAPPENS WHEN I LEAVE STATE EMPLOYMENT?

If you terminate employment, you may continue to file claims for qualifying expenses incurred during the calendar year until you have been reimbursed the balance in your account. Qualifying expenses include those incurred while you are employed by another employer or are actively looking for work.

You cannot participate in the dependent care FSA and be eligible for the dependent care tax credit. Before enrolling in the dependent care FSA, you should consult your tax advisor to see if it may be advantageous to take the dependent care tax credit.

flexible spending accounts

How to Enroll (in Flexible Spending Accounts)

If you wish to contribute to either of the FSAs, you must make a new election each year during the enrollment and change period. You must make a separate election for the Health FSA and the Dependent Care FSA. If you currently participate in one or both of the FSAs, you will automatically receive new enrollment forms from ASI, the State's FSA third party administrator.

When deciding how much to contribute to your account, estimate your expenses carefully. Once you enroll, you:

- will forfeit (use it or lose it) any unused account balance at the end of the calendar year;
- cannot change your contribution amount during the year unless you have a qualified employment or status change, such as marriage or divorce;
- cannot be reimbursed through the Dependent Care FSA and claim a dependent care tax credit for the same expense;
- cannot be reimbursed for a particular expense through the Health FSA and through any group or individual insurance;
- cannot be reimbursed through the Health FSA and claim the same expense as a tax deduction; and
- cannot move funds from one FSA to the other.

Please see your Personnel Assistant for the State of Iowa Enrollment Agreement Form or download a copy from the Iowa Department of Administrative Services's web site at: www.das.hre.iowa.gov/pdfs/Benefits/FSA_enrollment_form.pdf.

How to Make Changes (to FSAs During the Year)

In some situations, you may be able to change your FSA contribution levels. If you want to make a change, keep in mind that you must have a qualifying event (see the Summary Plan Description for a list of events) and that **any change in election must be filed within 30 days of the event.**

If the change is approved by ASI, your change will become effective on the first day of the month following the submittal of a completed change form. Any increase in your election can include only those expenses that you expect to incur during the period of coverage subsequent to the effective date of the increase.

Childbirth and adoption bear special mention. You have 30 days from the birth or adoption of a child to enroll in or increase your Health FSA. If you have missed work due to the birth or adoption of a child, you have 30 days from return to work to enroll in or increase your Dependent Care FSA.

deferred compensation

What's New for 2005

CONTRIBUTION LIMITS

Contribution limits for 2005 have increased to the limits shown below.

REGULAR LIMITS	50+ CATCH UP[2] LIMITS	3-YEAR CATCH-UP[3] LIMITS
The lesser of 100% of compensation[1] or:	For participants age 50 or older, the regular limit is increased by:	The total of the regular limit plus amount of missed contributions up to:
$14,000	**$4,000**	**$28,000**

1. Compensation is your gross salary minus retirement contributions (IPERS, POR, judicial retirement) . The maximum amount you may contribute may also be reduced by FICA deductions, insurances, flexible spending accounts, auto use maintenance, employee organizations, and assignments.
2. Participants are not able to use the 50+ Catch-Up benefit and the 3-Year Catch-Up benefit at the same time.
3. If you are within three years of your normal retirement date, you may qualify to contribute more than the regular maximum under the program's 3-Year Catch-Up Provision.

MATCH CHANGES

Effective January 1, 2005, UE/IUP employees will receive the employer match. For every $2 an employee contributes, the State will contribute $1, up to a maximum of $25 a month. UE/IUP employees who contribute to an active provider will have a match account opened automatically with that provider. The funds will be invested in your provider's fixed rate account until you reallocate your investments. If you invest with an inactive provider, you must select an active provider by November 30, 2004, so that your funds are invested with the first paycheck of January. Contact information for the four active providers is on the following page.

Effective January 1, 2005, the maximum monthly match increases from $25 to $50 for AFSCME, AFSCME Judicial, PPME, and non-contract employees. Employees who wish to increase their contributions to $100 or more a month must complete the State's New Account & Change Form and return it to their Personnel Assistants by December 15, 2004, to make the change effective for the first paycheck in January.

deferred compensation program

Program Basics

EXPLANATION OF BENEFIT

The Retirement Investors' Club is a voluntary retirement savings program designed to increase your personal long-term savings. Your contributions are invested on a pretax basis. Contributions and earnings are not taxed until you take the money out as income. The program (also referred to as deferred compensation) contains two plans, the 457 Employee Contribution Plan and the 401(a) Employer Match Plan. For more detailed information, visit our website at www.das.hre.iowa.gov/ric.

ELIGIBILITY

You are eligible to contribute if you are a permanent or probationary employee of the State of Iowa working 20+ hours per week or an employee who has a fixed annual salary. This program is not offered to Board of Regents Institution employees.

ENROLLMENT

The first step to enrollment is choosing your investment provider. Your provider has all the investment information and forms you need to open your account. You may access provider/product information online or call one of the following numbers.

AIG VALIC
800-892-5558 ext 88700
www.aigvalic.com

AXA Equitable
877-800-7279
www.equitable.com/iowa/

Hartford Life
800-424-2825 ext 47627
www.retire.hartfordlife.com

ING Financial Advisers
800-555-1970
www.ingretirementplans.com/index.shtml

HOW MUCH CAN I CONTRIBUTE?

Your contributions are taken from your paycheck before state and federal income taxes and deposited in your designated investment selections. You may choose to contribute as little as $25/month ($12.50 per pay period) or as much as $14,000 (regular limit), $18,000 (50+ Catch-Up), or $28,000 (3-Year Catch-Up).

You may elect to roll assets from your previous government employer's 457 plan into your 457 account at the State. You may also roll your previous 401(k), 401(a), 403(b), 403(a), IRA (traditional or rollover), or SEP into your State 401(a) employer match account.

Please Note: The total of all contributions made to this 457 plan and/or any other government employer's eligible 457 plan must not exceed the IRS maximum limits shown above.

WILL I RECEIVE AN EMPLOYER MATCH?

The State is offering a match to participants' 457 plan contributions. This match does not reduce your maximum contribution limit in your 457 account. The State will match $1 for every $2 you contribute to the 457 plan up to the maximum monthly limits shown below:

Employee Group	Maximum Match Amount
Executive Branch	
AFSCME-covered employees	$50/month
Non-contract employees	$50/month
SPOC-covered employees	$50/month
UE/IUP-covered employees	$25/month
Judicial Branch	
AFSCME-covered employees	$50/month
Non-contract employees	$50/month

WHAT ARE MY INVESTMENT OPTIONS?

Each active provider (AIG VALIC, AXA Equitable, Hartford Life, ING Financial Advisers) has many investment options ranging from conservative to aggressive. You have the option of choosing one or several investments including fixed rate accounts, mutual funds and variable annuities. Your investment selection should be based on your goals for your retirement savings, your risk tolerance, and the length of time you have to invest. These active providers offer you the option of changing your investment selections at any time.

HOW DO I GET MY MONEY OUT?

You do not have the option to receive a distribution from your RIC accounts while you are employed except in the case of an approved hardship withdrawal, cash out, or service credit purchase. Hardship withdrawals are only approved in rare circumstances, such as a significant loss of income or unexpected medical expenses that are not covered by insurance.

Once you terminate from employment, you are eligible to take distributions from your Retirement Investors' Club accounts.

If you are invested with one of the active providers, you do not need to contact the Department of Administrative Services. You may request a distribution directly from your active provider at the numbers listed below.

AIG VALIC	**888-568-2542** **515-267-1099 in Des Moines**
AXA Equitable	**877-800-7279 option 3** **515-225-1141 in Des Moines**
Hartford Life	**800-528-9009**
ING Financial Advisers	**800-555-1970** **515-698-7973 in Des Moines**

If you are invested with any provider other than the four listed above, please complete the State Distribution Form for Inactive Providers and call your provider to confirm whether or not you are also required to complete a provider distribution form.

deferred compensation program

WHAT ARE MY OPTIONS WHEN I RETIRE?

1. **Leave your assets fully invested** in RIC and defer paying taxes until age 70½ (or longer if still employed by the State) at which time you must begin taking at least the required minimum distributions annually. If you leave your assets in RIC, you have the option of changing your investment selections and/or provider at any time (some product restrictions may apply). Your 457 Employee Contribution Account will not be subject to a 10% penalty by the IRS if you take distributions before age 59½.

2. **Take income** in one of the following ways (some product restrictions may apply).
   - Total lump sum distribution
   - Partial lump sum distributions
   - Systematic/periodic payments
   - Lifetime payments

   For tax information on distributions, see the Special Tax Notice attached to your distribution form. Be sure to check with your provider for possible surrender charges.

3. **Roll over** all or a portion of your assets to a 457, 401(k), 401(a), 403(b), 403(a), IRA (traditional or rollover), or SEP. This is a non-taxable event. Once you roll your 457 employee contribution assets to a qualified plan or IRA, you may be subject to a 10% penalty by the IRS if you take distribution before age 59½.

additional employee benefits

Workers' Compensation

If you are injured on the job as a result of your employment, you may be eligible for Workers' Compensation benefits. Workers' Compensation benefits are provided to you by law and do not require any action by you to obtain coverage. Under Workers' Compensation, you may be eligible for wage replacement and medical care. If you sustain an injury or illness that you believe is work-related, you must notify your employer, who will ask that you complete a first report of injury. Your supervisor or personnel assistant can help you with this process.

Your first report of injury will be sent to Sedgwick Claims Management Services for evaluation and handling. Sedgwick CMS, a national third party administrator in the area of Workers' Compensation, assumed responsibility for the State of Iowa Workers' Compensation claims on July 1, 2001. They are responsible for claims intake, evaluation, direction of medical care, benefits payment, and all other aspects of the day-to-day handling of Workers' Compensation claims filed by state of Iowa employees.

If your claim is denied by Sedgwick CMS, a letter will be sent directly to you. This letter should be presented to your group health carrier if they deny medical coverage based on the Workers' Compensation filing. The Iowa Department of Administrative Services is responsible for the management of the program and the contractual agreement with Sedgwick CMS. This agreement became effective on July 1, 2001.

All communication and correspondence regarding Workers' Compensation claims to Sedgwick CMS should be directed to:

Sedgwick CMS
12119 Stratford Drive
Clive, Iowa 50325-8146
Phone: 515-327-4888
Fax: 515-327-4899
Toll Free: 866-342-3920
After Hours New Report Call Center: 866-222-8768

Employee Assistance Program (EAP)

WHAT IS THE EMPLOYEE ASSISTANCE PROGRAM (EAP)?

The Employee Assistance Program (EAP) is a service designed to provide confidential, professional assistance to help employees of the Executive and Judicial Branches of state government resolve personal problems. Services are provided by Employee & Family Resources (EFR), and include assessment, short-term counseling, and referral to appropriate community agencies.

EAP counseling services are provided by a private agency under contract with the state. The counselors are not state employees. Calls to EAP counselors are confidential within strict legal limits. They will not tell anyone you called or release any information without your written permission unless one of these legal exceptions (child or dependent adult abuse or neglect; life threatening situation) applies.

WHAT TYPES OF PROBLEMS DOES EAP COUNSELING COVER?

EAP counseling services are intended to help people before problems interfere with job performance. Problems for which the EAP counselors can provide help include:

- Alcohol or other drug abuse
- Marriage or family problems
- Financial consultation (budgeting, investing)
- Health or stress concerns
- Career struggles/job burn-out
- Death/dying issues
- Interpersonal conflicts
- Workplace conflicts
- Legal concerns (personal, non-employment related)

HOW DO I MAKE AN APPOINTMENT (WITH THE EAP)?

Appointments with EAP counselors are available some evening and weekend hours, as well as during business hours. You may see a counselor on your own time and no one will need to know. If you need to see an EAP counselor during work time, you will need to:

- Get approval from your supervisor for time away from work.
- Sign a release of information form provided by the EAP counselor. This allows the counselor to confirm your work time attendance with your supervisor. No other information will be released without your written permission.

CONTACTING THE EAP

515-244-6090 (Des Moines area) or
1-800-EAP-IOWA (or 1-800-327-4692) or
Outside of Iowa: 1-800-327-3020
Or visit EFR's web site at: www.efr.org/eap.

HOW MUCH WILL IT COST (TO GO TO EAP)?

There is no charge to you for services provided by the EAP. However, you are limited to three (3) sessions with an EAP counselor per incident. If an EAP counselor refers you to other resources for additional help, those resources may charge for their services. EAP counselors will work with you to identify resources that are affordable or that may be partially covered by your health insurance.

If you have questions about whether you are covered by the EAP, contact your Personnel Assistant or District Court Administrator.

continuing insurance coverage
after leaving state employment

COBRA

HEALTH AND DENTAL INSURANCE

If you leave state employment, the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) provides for continuation of health and dental benefits coverage at the group premium rate after your coverage with the State ends. However, certain events must occur for any persons covered under your contract to be eligible (see events below).

The State's share of the premium payment for health and dental benefits will cease at the end of the month in which the qualifying events occurs, and you will be responsible for full payment of the premium. COBRA coverage begins the first of the month following the qualifying event. The COBRA election period is 60 days after the later of:

- the date coverage would otherwise end, or
- the date of the "COBRA Notification/Election Form."

If your employment ends, the Iowa Department of Personnel will mail a "COBRA Notification/ Election Form" to you within two weeks following your last paycheck. The notification includes monthly benefit costs and election instructions. In the event of the death of an active employee, the family will receive notice of their COBRA rights. If an employee divorces, reduces hours, or has a dependent that is no longer eligible for coverage, the employee must notify his or her Personnel Assistant within 60 days following the event so that COBRA information can be sent.

PLEASE NOTE:

COBRA rights will not be extended to a Domestic Partner or his/her children, either if the relationship terminates, if the employee terminates from State employment, or if the domestic partner's children have an event that makes them ineligible for employee's plan.

EVENT:	MAXIMUM ELIGIBILITY PERIOD BEYOND TERMINATION
Employee Termination/ Resignation	The employee and covered dependents have 18 months of COBRA eligibility. If the employee meets the Social Security Administration's definition of disabled at any time during the first 60 days of COBRA coverage, the employee and covered dependents have 29 months of COBRA eligibility.
Death or Divorce of Employee	The covered dependents have 36 months of COBRA eligibility.
Employee Reduces Work Hours; No Longer Eligible	The employee and covered dependents have 18 months of COBRA eligibility.
Employee's Dependent No Longer Eligible (Age 19 and no longer a full-time student or marries)	The covered dependent has 36 months of COBRA eligibility.

continuing insurance coverage after leaving state employment

Life Insurance

When you leave State employment, your State-sponsored life insurance coverage ends. Depending on the reason you are leaving, you may have more than one option for continuing your life insurance coverage.

PORTABILITY

If you leave State employment for reasons other than disability or retirement, you may be able to continue your supplemental life and supplemental AD&D insurance through a portability provision. This provision is available if you have $20,000 or more of Supplemental Life coverage. Your Personnel Assistant will complete the employer section of the Life Insurance Portability Form; you are then responsible for contacting Prudential and submitting any required information to them. Once you receive this information, it is your responsibility to contact the insurance carrier, and any resulting coverage is provided under the terms of the group portability contract.

CONVERSION

If you have less than $20,000 of supplemental life insurance, or if you leave State employment due to retirement or because you qualify for Long Term Disability benefits, you can elect to convert your group term life insurance to an individual whole life policy through the life insurance carrier, currently Prudential Insurance Company of America. Your Personnel Assistant can provide you with the forms and information that you will need to convert your life insurance. Once you receive this information, it is your responsibility to contact the insurance carrier, and any resulting coverage becomes an individual contract between you and the insurance carrier.

Retirement

HEALTH AND DENTAL INSURANCE

(Excludes employees covered by the State Police Officers' Council)

When you retire, you can continue to participate in the State of Iowa group health and dental plans for life. The State's share of the monthly premium will cease at the end of the month in which you retire.Your coverage as a retiree will begin the first of the month following retirement; you will pay the full monthly premium for any insurance coverage you choose to keep.

You may drop your State group plan completely. However, there is currently no provision for rejoining the group at a later date. As a retiree, you will be able to participate in the annual enrollment and change period, which will allow you to change your health plan every year. You can continue your group health and group dental coverage separately or together. You do not have to elect to continue in both plans. Your benefits as a retiree are identical to benefits for the plan you held as an active employee.

You can also continue your coverage with the group if you become eligible for Medicare. It is your responsibility to submit proof that you have Medicare Parts A and B to your health insurance carrier. Medicare will become the primary payor on claims and the State group will pay as secondary. A premium rate reduction will occur at that time.

Generally, Medicare eligibility is granted when you turn age 65. It can also be granted at an earlier age if you have a disability. Once you become Medicare eligible, you may elect to drop the State group coverage and purchase a private Medicare Supplement Policy. A Medicare Supplement Policy differs from the State group in that the benefits provided vary by supplement option. If you continue with the State group plan after you become eligible for Medicare, your benefits do not change. Benefits offered to Medicare eligible retirees are the same as the benefit plan offered prior to becoming Medicare eligible.

In most instances for State of Iowa retirees, a retiree's surviving spouse, if covered at the time of the former employee's death, is allowed lifetime coverage with our group.

Employees in the Judicial Branch and Community Based Corrections have the option of using their unused sick leave to help pay for their retiree premiums until age 65.

Employees must see their Personnel Assistant for specifics and the required paperwork at the time of retirement.

LIFE INSURANCE

When you retire, your State-sponsored life insurance coverage ends. You can elect to convert your group term life insurance to an individual whole life policy through the life insurance carrier, currently Prudential Insurance Company of America. Your Personnel Assistant can provide you with the forms and information that you will need to convert your life insurance. Once you receive this information, it is your responsibility to contact the insurance carrier, and any resulting coverage becomes an individual contract between you and the insurance carrier.

Termination Due To Approval for Long Term Disability

HEALTH AND DENTAL INSURANCE

If you terminate employment upon approval for Long Term Disability (LTD), in lieu of COBRA coverage, you are allowed to continue your coverage with the State group for as long as you remain disabled according to the plan definition of disability. The State's share of the monthly premium will cease at the end of the month in which your employment terminates. LTD coverage will begin the first of the month following termination and you will pay the full monthly premium for any insurance coverage you choose to keep.

You may drop your state group plan completely. However, there is currently no provision for rejoining the group at a later date.

If you continue your insurance coverage with the State of Iowa group, you will be able to participate in the annual enrollment and change period, which will allow you to change your health plan every year. You can continue your group health and group dental coverage separately or together. You do not have to elect to continue in both plans. Your benefits as a member of the Retired/Disabled group are identical to benefits for the plan you held as an active employee.

If the LTD carrier determines that you are no longer eligible for LTD benefits and you are not drawing a retirement benefit, health and dental benefits will stop. You will need to purchase individual health and/or dental coverage at that time.

continuing insurance coverage after leaving state employment

You can also continue your coverage with the group if you become eligible for Medicare. It is your responsibility to submit proof that you have Medicare Parts A and B to your health insurance carrier. Medicare will become the primary payor on claims and the State group will pay as secondary. A premium rate reduction will occur at that time.

Generally, Medicare eligibility is granted when you turn age 65. It can also be granted at an earlier age if you have a disability. Once you become Medicare eligible, you may elect to drop the State group coverage and purchase a private Medicare Supplement Policy. A Medicare Supplement Policy differs from the State group in that the benefits provided vary by supplement option. If you continue with the State group plan after you become eligible for Medicare, your benefits do not change. Benefits offered to Medicare eligible persons are the same as the benefit plan offered prior to becoming Medicare eligible.

Employees must see their Personnel Assistant for specifics and the required paperwork at the time of termination of employment.

LIFE INSURANCE UNDER AGE 60

If you are under age 60 when you are approved for LTD, your life insurance automatically continues in the same amount that you maintained while you were working. You will not have to pay premiums for your coverage as long as you continue to be disabled according to the State's Long Term Disability insurance carrier. The insurance is subject to the normal age reductions of coverage in your group contract. Your group life insurance will be in effect as long as you remain disabled according to the group definition of disability, but, in no event, beyond the age of 70.

If your Long Term disability coverage ends, your life insurance coverage also ends. You can elect to convert your group term life insurance to an individual whole life policy through the life insurance carrier. Your Personnel Assistant can provide you with the forms and information that you will need to convert your life insurance.

OVER AGE 60

If you are age 60 or older on your date of disability (last active day at work), you can convert your group life insurance to an individual whole life insurance policy. This conversion privilege will be offered when a decision is reached on your claim. You must apply within 31 days from the end of the month in which you are notified in writing of your conversion rights. Monthly premiums must be paid continuously prior to the notice. Contact the Personnel Assistant with your department for the life conversion form.

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